MIND inquiry into acute and crisis mental health care

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Overview

The recent inquiry by MIND, while commending examples of good practice, found a number of areas in which service users are being let down during periods of crisis. These include bad practice in relation to restraint and control, but also overly medicalised responses and a lack of both humanity and urgency in responding to people in crisis. The recommendations have implications not only for local authorities’ own members of community mental health teams, but also for their strategic future role in leading health and wellbeing boards (in England) and supporting NHS and joint commissioning.

Briefing in full

The mental health charity MIND has carried out a year-long investigation into acute and crisis mental health care in England and Wales, including the response to emergency situations of community mental health teams. MIND’s panel of experts issued a call for evidence, held five hearings and visited a range of services.

The panel notes that it found some excellent care and applauds the hard work and dedication of staff and managers up and down the country. However, the panel also found some poor, or worse than poor practice and experiences and makes recommendations for change.

Crisis and acute mental health services are a crucial part of mental healthcare, providing for people when they are most unwell and vulnerable. The panel identified four key areas where work should be focused to raise all services to the level of the best. These are outlined below.

1. Humanity

The panel makes the general point that some mental health services have lost touch with basic humane principles when dealing with people in crisis – as shown by dirty wards, lack of human contact, a lack of respect often bordering on rudeness by staff, and a reliance on force. It recommends not only organisational commitment to a culture of humane values, service and hospitality, but also a rethinking of
‘professional values’, continual checking with those receiving services, staff support and development, including training in prevention, de-escalation and management of disturbed behaviour.

It also argues that face-down restraint should be ended and that acute services should work towards eliminating seclusion and restraint altogether. These recommendations have implications for mental health care in the community, as they would involve more such care in general and more acute care closer to people’s homes in smaller, less ‘medicalised’ units.

2. Commissioning for people’s needs

The main point under this heading is that commissioners and, in Wales, local health boards, should not assume that one model will fit all. Commissioners of acute and crisis care and local health boards should encourage flexibility and creativity in providing personalised and community-specific solutions. For example, different service models may be needed in rural and urban areas and access should be enabled to clinical mediation and advocacy involving specialist community organisations (eg those working with black and minority ethnic communities who still experience inequality in the area of mental health) in mainstream care provision.

3. Choice and control

The panel argues that there is an urgent need for more direct access options to urgent care services. This would mean that there should be an explicit acknowledgement that people with mental health problems know their own needs and should be able to self refer to services. The panel heard that often people were told that they were not ill enough or were too ill to meet the criteria for particular services. It points out that crisis plans that are jointly developed in an independently facilitated process have been shown to reduce the use of statutory powers to detain and treat people against their will.

4. Reducing the medical emphasis in acute care

The panel accepts that doctors can play a valuable role in supporting people with mental health problems, but points out that the needs people described in the course of their inquiry – care, safety, someone to listen, something to do – did not require a medically dominant response. Many people would prefer more peer support form people who have themselves experienced mental health problems. Examples given of this approach include the Leeds Survivor-Led Crisis Service and the Maytree sanctuary in north London, which recruits staff for their people and listening skills.

Recommendations

The panel makes a number of recommendations to address the issues outlined above. These are summarised below.

For commissioners and local health boards:

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- Review how far acute services are meeting local people’s requirements, and consult with black and minority ethnic communities in this process.
- Set clear standards for values-based services in the procurement or planning process and hold providers to account using measures that include service user/carer satisfaction.
- Expand the range of options to meet different needs; for example, crisis houses, host families and services provided by people with experience of mental health problems, and self-referral options.

For provider organisations:

- Consider ‘inpatients’ as ‘guests’ as well as recipients of care. Review the standards of hospitality that are being offered and ask the guests for their feedback.
- Commit to working without violence and reappraise control and restraint methods, in particular ending face-down holds.

For staff teams:

- Carry out jointly negotiated crisis planning with people who may need to access acute care in future.
- Plan and perform your work in the knowledge that people using services value time with staff and that empathy, kindness and respect go a long way.

For professional education providers:

- Market mental health professions and recruit on the basis of candidates’ values and personal qualities as well as skills.
- Re-evaluate how professional boundaries are taught so that staff are encouraged to be themselves with the people in their care.

Comment

While much of the acute care discussed in the report is currently provided in hospitals and is therefore of particular interest to the NHS, the implications of this report are that more care should be provided outside hospital and by non-medical staff. This would have implications for local government in various ways, including the ways of working and responsibilities of community mental health teams and in relationships with the voluntary sector. Unfortunately, many of the problems identified, such as closure of local units and unanswered calls to helplines are a result of financial savings currently required of the public sector.
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However, the report is also talking about a change of culture, particularly in the NHS, but it also touches on the issue of personalisation of commissioning and providing services, an issue with which local authority adult social care departments are very familiar and perhaps more experienced than their opposite numbers in the NHS. This means that, through health and wellbeing boards in England, increased integration of commissioning and services and health scrutiny committees/panels, local authorities may have a particular role to play in supporting the development of mental health strategies and commissioning plans across both health and social care which respond to the issues raised in this report.

For more information about this, or any other LGiU member briefing, please contact Janet Sillett, Briefings Manager, on janet.sillett@lgiu.org.uk